

Hospital Letterhead

Hospital ABN 6.

Date of Notice

Name of Patient

Admission Date

Address

Health Insurance Claim (HIC) Number

City, State, Zip Code

Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: *(Insert the name of the addressee.)*

We have reviewed the medical services you have received for *(specify services or condition)* from *(date of admission)* through *(date of last day reviewed)* and has determined that further hospitalization paid under Medicare is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)*. The *(name of QIO)* has concurred with our decision that beginning *(specify date of noncovered acute care day)* further *(specify services to be furnished or condition to be treated) (specify is/are)* medically unnecessary or could be safely furnished in another setting. You will also receive a notice from *(name of QIO)* confirming the review decision.

We have advised your attending physician of the denial of further acute hospital care. Upon receipt of this notice, the items and services which you receive will no longer be covered under Medicare. The care that you need now is not hospital or skilled nursing care and Medicare does not pay for it.

You are financially liable for all costs of the care you receive, except for those services for which you are eligible under Part B, beginning on *(specify date)*.^{1/} You should discuss other arrangements with your attending physician for any further health care you may require.

- **If you disagree with this decision and want an expedited reconsideration:**

You may request **by telephone or in writing** an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below.

- **If you do not request an expedited reconsideration:**

You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by *(name of QIO)*.

- **QIO Reconsideration Results:**

The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.

IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that your care is not covered by Medicare), you are responsible for payment beginning *(specify date)*^{1/}. If you leave the hospital on *(specify date)*^{1/}, you will not be liable for costs of care except for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

- **QIO Address:**

(QIO Name)

(Address)

(Telephone Number)

Sincerely,

*(Title, e.g., Chairperson of Utilization Review Committee,
Medical Staff, etc.)*

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from

_____ *Name of Hospital*
at _____ *Time* on _____ *Date*. I understand that my signature below
does not indicate that I agree with the notice, only that I have received a copy of the notice.

Signature of patient or authorized representative

Time

Date

cc: QIO

Attending Physician

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^{1/} Insert: The date of the day following receipt of the QIO and hospital notification.